Workplace violence: Prevalence, risk factors and preventive measures across the globe

Daniela ACQUADRO MARAN[1]

Affiliations:

[1] PhD, Assistant Professor, Department of Psychology, University of Turin, Turin, Italy.

Corresponding author:

Daniela Acquadro Maran, PhD, Università di Torino, Via Verdi 10 – 10124 Torino (Italy).
E-mail: daniela.acquadro@unito.it

Abstract

Workplace violence is a term referred both to physical and psychological violence that occurs at work. The investigation of this phenomenon is essential, because the knowledge about the nature of the prior relationship victim-perpetrator, the behaviour acted by the perpetrator and the strategies adopted by the victim to cope with the experience of victimization, the consequences on individuals, society and organization, give to scholars and practitioners significant information that could be useful to improve the organizational prevention and intervention.

This viewpoint described prevalence of workplace violence across the globe, as well as risk factors and preventive measures that employers may put in place in order to contrast this widespread phenomenon. Direct and indirect costs of workplace violence are high, thus governments and policymakers should address this issue with legislative interventions, supporting employers who have the task to carefully consider this psychosocial risk factor in their risk assessment process as well.

Riassunto

La violenza lavorativa è un termine che si riferisce alla violenza sia fisica sia psicologica che si verifica nell'ambiente di lavoro. La ricerca di questo fenomeno è essenziale, perchè la conoscenza della natura della relazione tra vittima e carnefice, il comportamento agito dal carnefice e le strategie adottate dalla vittima per reagire nei confronti dell'esperienza di vittimizzazione, le consequenze sugli individui, la società e le organizzazioni lavorative, danno agli studiosi ed ai medici informazioni significative che potrebbero essere utili per migliorare la prevenzione e gli interventi a livello organizzativo. Questo "viewpoint" ha evidenziato l'elevata prevalenza della violenza lavorativa in tutto il mondo, cosi come i fattori di rischio e le misure di prevenzione che i datori di lavoro devono mettere a punto per constrastare questo fenomeno diffuso. I costi diretti ed indiretti della violenza lavorativa sono alti, pertanto i governi ed i decisori politici dovrebbero affrontare questo problema con interventi legislativi, supportando i datori di lavoro che hanno il compito di considerare in modo attento anche questo fattore di rischio psicosociale nel loro processo di valutazione dei rischi.

TAKE-HOME MESSAGE

Workplace violence is a global public health problem, because it is a widespread phenomenon across the world and a reason of great concern for the consequences that it may have for employers, workers and economies.

Competing interests - none declared.

INTRODUCTION

Violence in the workplace is one of the most frequent and discussed phenomena, the importance of which is increasing, especially because of the negative consequences that such occurrences have on victims at the emotional, psychological and physical levels. Physical violence in the workplace has been defined by World Health Organization [1] as: "The use of physical force against another person or group, that results in physical, sexual or psychological harm. It includes, among others, beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching". In addition, psychological violence has been defined as: "The intentional use of power, including threat of physical force, against another person or group, that can result in harm to physical, mental, spiritual, moral or social development. It includes verbal abuse, bullying/mobbing, harassment and threats". The investigation of physical and psychological violence is essential, because the knowledge about the nature of the prior relationship victim-perpetrator, the behaviour acted by the perpetrator and the strategies adopted by the victim to cope with the experience of victimization, the consequences on individuals, society and organization, give to scholars and practitioners significant information that could be useful to improve the organizational prevention and intervention.

Aim of this viewpoint was to describe prevalence of workplace violence across the globe, as well as risk factors and preventive measures that employers may put in place in order to contrast this widespread phenomenon.

DISCUSSION

Prevalence of workplace violence across the globe

According to a report titled "Workplace Violence and Harassment: a European Picture" [2], in a sample of approximately 44,000 individuals, 6% of the European workers reported being exposed to threats of physical violence by colleagues (2%) or other people (4%). In the USA, the Occupational Safety and Health Administration (OSHA) noted that an average of nearly 2 million U.S. workers reported having been a victim of violence at work [3]. In its survey on the safety of citizens conducted between 2015 and 2016, the Italian Institute of Statistics (Istat) stated that some 8 million women and 3.754 million men claimed to have been victims of sexual blackmail or physical violence in the workplace [4]. These numbers account for almost 10% of female workers, which means that at least one in 10 women could experience one of these aggressive behaviours during their working lives. In particular, the Istat survey focused on sexual blackmail used as a tool to obtain or maintain a job or to achieve career advancement. This type of harassment, which in most cases (80.9%) is not reported by the victim, involves resignation, intentions to leave, dismissal, redundancy or non-employment.

According to the Bureau of Labor Statistics [5], the occupational sectors most at risk are those of health, social services, trade, education, transport, catering, public administration and defence. The Census of Fatal Occupational Injuries of the Bureau of Labor Statistics, based on Elliot's studies [6], noted that health workers are 16 times more at risk of violence than other workers. The reasons for this victimization are related to the particular nature of the health care professional; they are deeply in contact with suffering people and their relatives/friends. Findings from the European Survey on Working Conditions [7] show that more than 20% of the health sector workforce in the European Union (EU-27) has experienced some form of negative social behaviour during the last 12 months of work, such as verbal abuse, unwanted sexual attention, threats, humiliating behaviour, physical violence, bullying and sexual harassment

In particular, two EWCS surveys (2005-2010) have shown that violent behaviour towards healthcare workers, mostly by patients and their families, represents a serious and dangerous occupational risk that is constantly increasing [8-15]. The rates were 16% for threats of physical violence and 15% for physical violence during the previous year

of work, which are three times the respective averages of other European employment sectors. Findings from an investigation that involved 77,681 nurses from ten European countries indicated an unacceptable level of violence by patients and relatives and considerable variability between countries. Higher rates of violence were found in France, the United Kingdom and Germany, while lower rates were found in Norway and the Netherlands [16]. In Italy, in 2013, the National Institute for Labour reported approximately 4,000 injuries caused by aggression or violence by strangers; 1,200 of them occurred in the health sector [17]. An investigation by the National Health Service (NHS) published in 2017 indicates that 13% of British hospital staff report having been bullied by managers, 18% by their work colleagues and 28% by patients and/or relatives. A worrying fact is that only 48% of bullying accidents are reported, which suggests that the problem is underrepresented. However, intervention is crucial to help the victim cope with such a stressful event. Direct or witnessed contact with violence exposes healthcare workers to dissonant and contradictory experiences, since, on the one hand, they are in the role of 'rescuers' and carriers of care, while on the other hand, they experience situations of threat and aggression. Consequences affect these victims at the emotional, relational and behavioural levels. Moreover, when these workers are in a threatening relational climate, the personological characteristics of the operator are intertwined with defence mechanisms, behavioural reactions and a lack of focus on what are called 'non-technical skills', which are the behavioural competences [18].

Factors for victimization in the workplace

The factors that make subjects more susceptible to victimization can be individual, contextual or structural. At the individual level, age, gender, professional experience and relationship with the perpetrator are important variables. In particular, in the health sector, the most affected professional figure is that of nurses [19], and among them, the most at

risk are young women with little experience who are in direct contact with the patient or caregiver. At the contextual level, there is the presence or absence of support, the psychosocial environment, the activities carried out, the presence of clear and shared rules, and the possibility of the early intervention of guards in the event of violent behaviour. At the structural level, there is the physical environment, lighting and the presence or absence of rules of access to the departments [20].

Investigations on this phenomenon have reported that in some departments, the risk of victimization is higher than in other departments, i.e., emergency rooms and psychiatric wards [21, 22]. Moreover, investigations have been conducted in infectious disease wards [23], radiology and radiotherapy [24, 25], home care [26], surgery wards [27], long-term care and geriatric wards [28], physical therapy [29], hospital wards [30] and intensive care units [31].

Morrison [32] considered the emergency room as an indicator of the functioning of a health organization, since it is the interface between the service, the hospital and the community. In particular, in emergency departments (a), the workers are in close daily contact with patients who are experiencing altered emotional and physical conditions, (b) the workers experience highly stressful situations due to the high number of daily accesses and long waiting times, and (c) there is frequently a lack of security systems and adequate staff training regarding the recognition and management of aggressive patients [33, 34]. In Italy, data from a survey carried out in 14 regions showed that 90% of the nurses interviewed reported having been subjected to verbal assaults, and 35% had experienced physical violence [35].

A survey carried out in 2009 in relation to the topic of workplace violence in US emergency rooms showed that in a sample of 3,211 first-aid nurses, 11.0% (range 8.3%-12.8%) reported having suffered workplace physical violence within the last week, and 43.8% (range 42.4%-45.7%) had been threatened or verbally abused [36]. These data were con-

firmed in a subsequent investigation that involved 7,169 nurses [37].

Physical violence and verbal violence occur more frequently in psychiatric wards [38]. In a study by Carabellese and Mandarelli [39] that focused on the safety of workers in public psychiatric services, the authors argue that the risk of mental patients committing violent acts against health professionals increases when mental illness is associated with factors such as substance abuse [40, 41], being male [42], having a long clinical history [43], previous hospitalizations [44] and non-adherence to psychopharmacological therapies. Moreover, the risk is greater if a lack of the observance of medication imposed by therapy is associated with the use of substances [45].

How to prevent the phenomenon

Psychosocial hazards have been described as key emerging issues that are not limited to work-related stress, but include high emotional demands, lateral violence, bullying and harassment. They are recognized as major challenges to occupational health and safety, and major concerns leading to burnout syndrome and several organizational outcomes such as low productivity and high turnover. In Europe, not only work-related stress but all psychosocial risk factors have to be evaluated by every employer, in the framework of occupational health and safety regulation, through a specific and thorough occupational risk assessment [46, 47].

The Occupational Safety and Health Administration (OSHA) offered guidelines for the prevention of violence in the workplace for health and social workers [48]. They include the following aspects: 1) Commitment of management and employee involvement; 2) a predefined programme; 3) analysis of workplaces; 4) prevention and risk assessment; 5) training and education; 6) data tracking and evaluation of prevention programmes. These guidelines also include tools such as checklists, sample surveys and reports to simplify risk analysis and programme implementation. According to the WHO, prevention of workplace violence can take place on three levels:

Primary, secondary and tertiary. Moreover, according to some authors, prevention should be similar for all working environments since none are excluded from the possibility of violent episodes [49]. Primary prevention means that all strategies aim to focus on the phenomenon before an episode occurs. Effective phases of this type of prevention include the selection of aspects related to the goodness of adaptation to the work task, education on the recognition of violence by supervisors and managers, and the facilitation of the resolution of non-violent conflicts. Jeffery [50] proposes the theory of crime prevention through environmental design, developed for workers in supermarkets and petrol stations to reduce the incidence of violence in these professional contexts. The planned strategies aim to demotivate the perpetrator before he/she commits any violent action; these strategies include spontaneous surveillance, natural control activities and territorial reinforcement. Spontaneous surveillance in supermarkets includes lights, interior and exterior, a clear field of view and, in some cases, cameras. The reinforcement of territoriality occurs when the number of clerks/and cash registers are high, and every border of the commerce is clearly marked and defined. These strategies send out clear messages of no tolerance to aggressive customers. Control activities occur when the management is interested in the purchase of safety devices and increase the number of staff members during the most critical hours. Secondary prevention comes into play during a preliminary phase of reconnaissance and rapid intervention to avoid serious consequences [49]. Tertiary prevention aims to minimize the harmful consequences of the violence episodes; individual psychological support is an example of a tertiary prevention strategy. Wilkinson [51] points out that managers have the responsibility and obligation to assess the risk of violence and to develop prevention programmes based on the risk experienced by employees. First, an evaluation should address the analysis and identification of the most endangered workplaces, because not all work contexts are equally likely to lead

to aggressive behaviour. It is important that intervention actions play a role in anticipation and reaction. According to the author, organizational policies of zero tolerance are the basis from which to start; the term 'zero tolerance' implies that threats and physical violence are considered unacceptable, without any reference to the consequences these actions entail. Another important strategy is that of an intervention team. This group of people can assess and deal with a threatening situation if it does occur. Persons with appropriate skills could include human resources staff in order to obtain information on collaborators and management, safety staff, health and mental health professionals for possible psychological assessments or to give support in case of trauma and injury, and finally, legal professionals that are useful on those unpleasant occasions when violent behaviour has legal repercussions. In addition, employee training regarding the identification, evaluation and management of critical situations, together with an effective and efficient communication system, are considered key elements of prevention activities [51]. These prevention measures should be put in place by employers in the framework of occupational health and safety regulation, that is, however, fragmented and heterogeneous at global level. A descriptive analysis showed that most countries across the globe have not included mandatory psychosocial risk assessment and prevention in their national occupational safety and health legislation. Furthermore, there are differences between developing and developed countries, which more frequently have legislative measures, with unequal levels of workers' protection and adverse effects on global health [52].

CONCLUSION

Workplace violence is a global public health problem, because it is a widespread phenomenon across the world and a reason of great concern for the consequences that this risk factor could have for employers, workers and economies. At organisational level, research indicated high turnover, absenteeism, high level of conflict among workers, and low productivity. At individual level, research showed psychological problems such as high levels of burnout, depression, post-traumatic stress disorders, and sleep disturbances, and physical problems ranging from minor injuries to death [53]. Direct and indirect costs of workplace violence are high, thus governments and policymakers should address this issue with legislative interventions, supporting employers who have the task to carefully consider this psychosocial risk factor in their risk assessment process.

References

1.   Bhutta ZA. Ethics in international health research: a perspective from the developing world. Bull World Health Organ. 2002;80:114-120.

2.   Milczarek M. Workplace violence and harassment: a European picture. Bruxelles: Publications Office of the European Union; 2010.

3.   Cooper C, Swanson N. Workplace violence in the health sector. State of the art. Geneva: Organización Internacional de Trabajo, Organización Mundial de la Salud, Consejo Internacional de Enfermeras Internacional de Servicios Públicos. 2002.

4.   Istat. Violenza sui luoghi di lavoro [cited 2020 Febr 20]. Available from: https://www4.istat.it/it/violenza-sulle-donne/il-fenomeno/violenza-sul-luogo-di-lavoro.

5.   LeBlanc MM, Barling J. Workplace aggression. Curr Dir Psychol Sci. 2004:9-12.

6.   Smith-Pittman MH, McKoy YD. Workplace violence in healthcare environments. In Nursing Forum. Oxford, UK: Blackwell Publishing Ltd; 1999, pp 5-13.

7. European Working Condition Survey [cited 2020 Febr 20]. Available from https://www.eurofound.europa.eu/surveys/european-working-conditions-surveys-ewcs.

8. Beech B, Leather P. Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. Aggress Violent Behav. 2006;11(1):27-43.

9. Camerino D, Estryn-Behar M, Conway PM, van Der BI, Hasselhorn HM. Work-related factors and violence among nursing staff in the European NEXT study: a longitudinal cohort study. Int J Nurs Stud. 2008;45(1):35-50.

10. Ferns T. Violence, aggression and physical assault in healthcare settings. Nurs Stand (through 2013). 2006;21(13):42.

11. Gascón S, Martínez-Jarreta B, González-Andrade JF, Santed MÁ, Casalod Y, Rueda MÁ. Aggression towards health care workers in Spain: a multi-facility study to evaluate the distribution of growing violence among professionals, health facilities and departments. Int J Occup Environ Health. 2009;15(1):29-35.

12. Gascon S, Leiter MP, Andrés E, Santed MA, Pereira JP, Cunha MJ, et al. The role of aggressions suffered by healthcare workers as predictors of burnout. J Clin Nurs. 2013;22(21-22):3120-3129.

13. Hahn S, Zeller A, Needham I, Kok G, Dassen T, Halfens RJ. Patient and visitor violence in general hospitals: a systematic review of the literature. Aggress Violent Behav. 2008;13(6):431-441.

14. Hahn S, Hantikainen V, Needham I, Kok G, Dassen T, Halfens RJ. Patient and visitor violence in the general hospital, occurrence, staff interventions and consequences: a cross-sectional survey. J Adv Nurs. 2012;68(12):2685-2699.

15. Roche M, Diers D, Duffield C, Catling-Paull C. Violence toward nurses, the work environment, and patient outcomes. J Nurs Scholarsh. 2010;42(1):13-22.

16. Estryn-Behar M, Van Der Heijden B, Camerino D, Fry C, Le Nezet O, Conway PM, et al. Violence risks in nursing—results from the European 'NEXT'Study. Occup Med. 2008;58(2):107-114.

17. Bressi C, Porcellana M, Gambini O, Madia L, Muffatti R, Peirone A, et al. Burnout among psychiatrists in Milan: a multicenter survey. Psychiatr Serv. 2009;60(7):985-988.

18. Sossai D, Molina FS, Amore M, Ferrandes G, Sarcletti E, Biffa G, et al. Analysis of incidents of violence in a large Italian hospital. Med Lav. 2017;108(5):6005.

19. Inail. Dati Inail 2005 [cited 2020 Febr 20]. Available from: https://www.inail.it/cs/internet/comunicazione/pubblicazioni/dati-inail/n669540987_dati-inail-2005.html.

20. Cooper C, Swanson N. Workplace violence in the health sector-State of the Art. Geneva: ILO. ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector; 2002.

21. Grottoli E, Ciriello S, Gabriele M, Giudice A, Lilli M, Mammi F, et al. Assaults and nuisances in health care environment. G Ital Med Lav Erg. 2007;29(3 Suppl):653-655.

22. Iozzino L, Ferrari C, Large M, Nielssen O, De Girolamo G. Prevalence and risk factors of violence by psychiatric acute inpatients: a systematic review and meta-analysis. PloS One. 2015;10(6).

23. Magnavita N. The exploding spark: workplace violence in an infectious disease hospital—a longitudinal study. Biomed Res Int. 2013;2013.

24. Magnavita N, Fileni A, Pescarini L, Magnavita G. Violence against radiologists. I: prevalence and preventive measures. Radiol Med. 2012 Sep 1;117(6):1019-1033.

25. Magnavita N, Fileni A. Work stress and metabolic syndrome in radiologists: first evidence. Radiol Med. 2014;119(2):142-148.

26. Campbell CL, McCoy S, Burg MA, Hoffman N. Enhancing home care staff safety through reducing client aggression and violence in noninstitutional care settings: A systematic review. Home Health Care Manag Pract. 2014;26(1):3-10.

27. Kim SC, Ideker K, Todicheeney-Mannes D. Usefulness of aggressive behaviour risk assessment tool for prospectively identifying violent patients in medical and surgical units. J Adv Nurs. 2012;68(2):349-357.

28. McPhaul KM, Lipscomb JA. Workplace violence in health care: recognized but not regulated. Online J

Issues Nurs. 2004;9(3):7.

29. Stubbs B, Dickens G. Physical assault by patients against physiotherapists working in mental health settings. Physiotherapy. 2009;95(3):170-175.

30. Viotti S, Gilardi S, Guglielmetti C, Converso D. Verbal aggression from care recipients as a risk factor among nursing staff: a study on burnout in the JD-R model perspective. Biomed Res Int. 2015;2015.

31. Arnetz JE, Hamblin L, Essenmacher L, Upfal MJ, Ager J, Luborsky M. Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports. J Adv Nurs. 2015;71(2):338-348.

32. Morrison LJ. Abuse of emergency department workers: An inherent career risk or a barometer of the evolving health care system?. CMAJ. 1999;161(10):1262-1263.

33. Bernaldo-De-Quirós M, Piccini AT, Gómez MM, Cerdeira JC. Psychological consequences of aggression in pre-hospital emergency care: cross sectional survey. Int J Nurs Stud. 2015;52(1):260-270.

34. Gacki-Smith J, Juarez AM, Boyett L, Homeyer C, Robinson L, MacLean SL. Violence against nurses working in US emergency departments. J Nurs Admin. 2009;39(7/8):340-349.

35. Becattini G, Bambi S, Palazzi F, Lumini E. Il fenomeno delle aggressioni agli operatori di Pronto Soccorso: la prospettiva italiana. In ANIARTI, Atti XXVI Congresso Nazionale ANIARTI 2007 Oct (pp. 535-541).

36. Wilkinson S. How nurses can cope with stress and avoid burnout. Emerg Nurs. 2014;22(7).

37. Emergency Nurses Association. Workplace violence against nurses remains high, according to new report. Des Plaines, IL: The 2011 Emergency Department Violence Surveillance Study. Des Plaines, IL: Emergency Nurses Association, Institute for Emergency Nursing Research 2011 [cited 2020 Febr 20]. Available from https://www.ena.org/docs/default-source/resource-library/practice-resources/workplace-violence/2011-emergency-department-violence-surveillance-report.pdf?sfvrsn=5ad81911_6.

38. Ferri P, Reggiani F, Di Lorenzo R. I comportamenti aggressivi nei confronti dello staff infermieristico in tre differenti aree sanitarie. Prof Inferm. 2011;64(3).

39. Carabellese F, Mandarelli G. Is involuntary psychiatric hospitalization a measure for preventing the risk of patients' violent behavior to self or others? A consideration of the Italian regulation. J Psychopathol. 2017;23(2):91-97.

40. Bennett T, Holloway K, Farrington D. The statistical association between drug misuse and crime: A meta-analysis. Aggress Violent Behav. 2008;13(2):107-118.

41. Carabellese F, Candelli C, Martinelli D, La Tegola D, Catanesi R. Cannabis use and violent behaviour: a psychiatric patients cohort study in Southern Italy. Riv Psichiatr. 2013;48(1):43-50.

42. Barlow K, Grenyer B, Ilkiw-Lavalle O. Prevalence and precipitants of aggression in psychiatric inpatient units. Aust NZ J Psychiat. 2000;34(6):967-974.

43. Torrey EF. The prevalence of schizophrenia in Ireland. Arch Gen Psychiatry. 1994;51(7):513.

44. Witt K, Van Dorn R, Fazel S. Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies. PloS One. 2013;8(2).

45. Monahan J, Steadman HJ, Robbins PC, Silver E, Appelbaum PS, Grisso T, et al. Developing a clinically useful actuarial tool for assessing violence risk. Br J Psychiatry. 2000;176(4):312-319.

46. Chirico F. The assessment of psychosocial risk: only "work-related stress" or something else? Med Lav. 2015;106(1):65-66.

47. Chirico F. The forgotten realm of the new and emerging psychosocial risk factors. J Occup Health. 2017;59(5):433-435. doi: 10.1539/joh.17-0111-OP.

48. Gallant-Roman MA. Strategies and tools to reduce workplace violence. AAOHN J. 2008 Nov;56(11):449-454.

49. Olson NK. Workplace violence: theories of causation and prevention strategies. AAOHN J. 1994;42(10):477-482.

50. Jeffery CR. Crime prevention through environmental design. Beverly Hills, CA: Sage Publications; 1977.

51. Wilkinson C. Fundamentals of health at work. CRC Press; 2001.

52. Chirico F, Heponiemi T, Pavlova M, Zaffina S, Magnavita N. Psychosocial Risk Prevention in a Global Occupational Health Perspective. A Descriptive Analysis. Int J Env Res Public Health. 2019;16(2470). doi: 10.3390/ijerph16142470.

53. Magnavita N, Di Stasio E, Capitanelli I, Lops EA, Chirico F, Garbarino S. Sleep Problems and Workplace Violence: A Systematic Review and Meta-Analysis. Front Neurosci. 2019;13:997. doi:10.3389/fnins.2019.00997.